Certification of Disability for the Handicapped Children's Provision

Insured and/or Administered by
Connecticut General Life Insurance Company
CIGNA HealthCare
Hartford, CT 06152

CIGNA

POLICYHOLDER	ACCOUNT NO.	DIVISION

This is to certify that _____ , _____
(Name of Handicapped Child) *(Birth Date)*

is (1) my unmarried child, (2) mentally and/or physically incapable of earning his own living, (3) became so incapable, while unmarried, prior to the attainment of the limiting age of 19 for a child's coverage under this policy, or between the ages of 19 and 23 while a full-time student and while primarily supported by me, and is (4) solely dependent upon me for support and maintenance.

With respect to this child, I am requesting the continuance of the dependent's coverage clause which would otherwise terminate on the date of this individual becoming ineligible under my Group policy because of age.

I understand that Connecticut General Life Insurance Company and/or CIGNA HealthCare reserves the right to examine my child periodically at its own expense, and if this continuance of coverage is approved, such insurance for this child would terminate as of the date of recovery, or if any of the above four conditions are no longer satisfied.

The above named child has been insured as an eligible dependent since _____.
(Date)

I hereby authorize any physician, hospital, pharmacy, insurance company, employer or organization to release any information regarding the medical history, treatment, disability or benefits payable for this claim to Connecticut General Life Insurance Company and/or CIGNA HealthCare for the purpose of validating and determining benefits payable in connection with this claim. Data without personal identification may be extracted for use in statistical studies.

This authorization or photostatic copy of original shall be valid for one year from date of signature.

SIGNATURE OF EMPLOYEE	DATE
POLICYHOLDER'S AUTHORIZED REPRESENTATIVE	DATE

Proof of Handicapped Child's Disability
Attending Physician's Statement of Disability

NAME OF PATIENT	SOCIAL SECURITY NO.	DATE OF BIRTH

ADDRESS *(Street)* *(City)* *(State)* *(Zip Code)*

1. HISTORY

A. WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN? *(Month, Day, Year)*

B. DATE PATIENT CEASED WORK BECAUSE OF DISABILITY *(if applicable)* *(Month, Day, Year)*

C. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? IF "YES", STATE WHEN AND DESCRIBE.

☐ Yes ☐ No

2. PRESENT CONDITION

A. DID THIS INCAPACITY EXIST PRIOR TO THE DEPENDENT'S 19TH BIRTHDAY?

☐ Yes ☐ No If not, how old was the individual when the incapacity commenced? _____

B. SUBJECTIVE SYMPTOMS

C. OBJECTIVE SYMPTOMS *(Include results of current X-rays, EKG's, or any other special tests)*

D. IS THE PATIENT:

☐ Ambulatory? ☐ Bed Confined? ☐ House Confined? ☐ Hospital Confined?

3. DIAGNOSIS

4. TREATMENT

A. DATE OF FIRST VISIT *(Month, Day, Year)*

B. DATE OF LAST VISIT *(Month, Day, Year)*

C. FREQUENCY OF VISITS

☐ Weekly ☐ Monthly ☐ Other_____

D. WHEN DID YOU LAST EXAMINE THE PATIENT? *(Month, Day, Year)*

E. DEGREE OF PSYCHIATRIC IMPAIRMENT

☐ None ☐ Mild ☐ Severe

F. DEGREE OF PHYSICAL IMPAIRMENT

☐ None ☐ Mild ☐ Severe

G. IS THIS PATIENT CAPABLE OF HOLDING ANY TYPE OF EMPLOYMENT AT THIS TIME?

☐ Yes ☐ No (If "Yes", please comment.)

5. HOSPITAL(S)

NAMES OF HOSPITAL(S) (IF EVER ADMITTED AS AN IN-PATIENT) DATE(S) OF ADMISSION DATE(S) OF DISCHARGE

6. PROGRESS

☐ Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed

DATE	SIGNATURE OF ATTENDING PHYSICIAN		
DEGREE	TELEPHONE	SOCIAL SECURITY NUMBER	TAX ID NUMBER

ADDRESS *(Street)* *(City)* *(State)* *(Zip Code)*